

- f) means for the sponsor to pay the administrator;
- g) means for the patient to pay the administrator; and
- h) whereby said system operates without the health care providers sending bills to the patients and without the sponsor sending bills to the patient, and whereby said system operates without any other entities involved in the system besides the administrator, the plan sponsor, the health care providers, and the patients.

### REMARKS

This Amendment is filed in conjunction with a Request for Continued Examination to ensure that this Amendment is entered. This amendment cancels all previously pending claims and presents a new "clean" set of claims. Some of the new claims are analogous to claims previously presented.

The Applicants maintain that their system and method of processing health care claims is significantly different and offers great advantage over previous systems, including the system/method presented by the primary cited reference, U.S. 6,012,035 to Freeman. The Applicants' approach focuses on streamlining communication (by reducing the number of communications/reports/statements and reducing the number of entities involved in the system) and payments amongst the entities involved in the process by aggregating multiple claims collected over a period of time.

The Applicants' process revolves around one central entity, reducing the total number of entities involved in the process. Claim 23 recites a system involving the insured patient, the health care provider, the administrator and the plan sponsor. This streamlined system involving just four entities offers significant advantages. In contrast, the Freeman system involves the many entities that are commonly involved in the processing of an insurance claim. For comparison:

*confusing!  
expert about  
computer systems  
computer networks  
network entities  
network access*

<u>Applicants' Entities</u>	<u>Freeman's Entities</u>
Employee/Insured/Patient	Health Care User
Health Care Provider (e.g. doctor, clinic)	Health Care Provider
Administrator	Management Service
	Financial Institution/Bank
Employer/Plan Sponsor	Health Care Purchasing Members (e.g. employers)
	Insurance Company

Freeman describes a process that requires communication about health care claims involving at least six entities, including a financial institution, a management service and an insurance company. Freeman offers no suggestion of a system operating with fewer entities (except that he explains that the insurance company might be the employer in an employer-insured plan). Instead, Freeman has devised a complex system to work within the typical communication maze of these many entities. For example, Freeman describes that the patient receives both a monthly bill from the bank (columns 33-34: "JCB Bills Patient for Patient Pay Portion"), as well as a statement from the insurance company (columns 33-34: "INS produces EOB and Distributes to Provider and Patient"). Further, the provider receives payment from the bank (columns 29-30: "JCB faxes Notice of Transfer to Provider/Payee the day of the funding") and receives a separate EOB from the insurance company company (columns 33-34: "INS produces EOB and Distributes to Provider and Patient"). It is this multiplicity of communications that Applicants' system and method seeks to avoid.

Claim 19 recites that the report from the administrator to employer/sponsor batches all claims for all covered employees from all providers over a period of time: "said entity reporting to sponsor on a periodic basis the aggregate amount owed by sponsor for services rendered for the covered patients during the period." This feature was recited in claim 3 as well as other previously-pending claims. In rejecting claim 3

under 35 U.S.C. §102(e) on the basis of Freeman, the Examiner cited step 114 in FIG. 3 of Freeman, and cited no other description in the specification or appendix. Step 114 in FIG. 3 says "Insurance Co. and Patient Pay Bank". The Applicant respectfully submits that this disclosure does not in any way describe or suggest that a bill is provided to the insurance company from the management service, or that any such bill contains an aggregation of all claims during a time period for all covered claims for a particular insurer.

Further, step 114 in FIG. 3 of Freeman does not show or suggest that the insurer pay an administrative entity in a lump sum for aggregated claims over a period. This feature of the Applicants' method is recited in claim 20.

Another advantageous feature of the Applicants' system and method is that the number of communications from the administrator to each entity are reduced as a result of the batching of claims over a given period. For example, claim 21 recites that the periodic report provided to the employee includes all services rendered to the employee and his/her family members over a predetermined period of time and that this report is sorted by family member: "said entity reporting to employees on a periodic basis the amount owed by employee for provider services rendered during a predetermined period on behalf of the employee and the employee's covered family members, said report to employee being sorted by family member." This grouping and sorting offers great advantage because the report is considerably easier for the employee to understand and the employee does not receive multiple statements for various members of the family. Freeman, in contrast, does not explicitly describe that a bill or report to the insured includes all of the health care services for a whole family. The Examiner has asserted that if only one family member is involved, the bill will inherently be sorted by family member. Nevertheless, Freeman is silent as to whether a

bill would include all data for a whole family when the family has multiple members receiving health care services over a given period, or whether such information would be conveniently sorted by family member.

Yet another advantageous feature of the Applicants' system and method is the use of plain language explanations of services rendered on the report that is provided to the employee/insured. The Examiner asserts that a standard bill will inherently include language which is plain enough to permit the patient to understand that payment is being required. Claim 22 recites that the language is plain as to the description of services – not that the language is plain as to the fact that payment is due. This is a departure from prior billing practices in which codes or very abbreviated explanation are provided which are often incomprehensible to patients. Freeman does not discuss the problem of coded bills, nor make any showing or suggestion that the reports provided to the insured read any differently than standard coded bills.

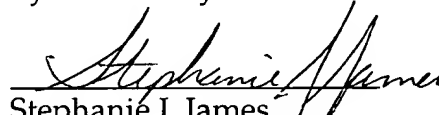
### CONCLUSION

All of the claims remaining in this application should now be seen to be in condition for allowance. The prompt issuance of a notice to that effect is solicited.

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Respectfully submitted,  
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